

With Child, Without Rights?: Restoring a Pregnant Woman's Right to Refuse Medical Treatment Through the HIV Lens

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ABSTRACT: In *Doe v. Division of Youth & Family Services*,¹ a hospital employee sought state intervention when an HIV-positive woman refused to comply with treatment recommendations during her pregnancy that would drastically reduce the chances of mother-to-child-transmission (MTCT), eventually triggering a lawsuit against the hospital. With an increase in the number of HIV-positive women becoming pregnant and the courts avoiding constitutional analysis of a woman's right to refuse medical treatment, there is a clear void where legal analysis is surely needed. This Article fills this void for the inevitable case where an HIV-positive pregnant woman's right to refuse medical treatment is weighed against the state interest in the fetus. Abortion case law recognizes and upholds the state interest in fetal *life*, but state interest in fetal *health* has yet to be established as a compelling interest which may override the constitutionally protected right of the woman. Meanwhile, compelled-treatment jurisprudence has unfailingly relied on protecting the potentiality of life. As such, this Article demonstrates that prior precedent demands a pregnant woman's liberty interest in bodily integrity be protected, as opposed to further relegating pregnant women into a group of second-class citizens whose right to refuse treatment is weakened by the mere fact of pregnancy. In ignoring prior jurisprudence, a court would sustain the stigma surrounding HIV and cause regression in education. Meanwhile, examining the issue through a public health lens reveals that a genuine interest in fetal health would support education rather than compelled treatment to ensure HIV-positive pregnant women are not driven from the health care system they clearly need.

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1. 148 F. Supp. 2d 462 (D.N.J. 2001).

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HIV is the leading cause of death worldwide for women ages 15 to 49.² In the United States, despite overall incidences of HIV infection remaining stable, young women from racial minority groups are more likely to be infected than ever before.³ Young women ages 13 to 39 account for approximately 64% of new HIV cases among women, with the youngest women in that age bracket accounting for more than a third of all new infections.⁴ Racial minorities are disproportionately represented in these outcomes: nearly 80% of the cases in these age groups are African-American and Hispanic women.⁵

Part of the explanation for this dramatic rise in infections for women, and young women specifically, is that heterosexual transmission is becoming an increasingly common cause of new HIV infections.⁶ Women are physiologically more susceptible to HIV infection than men⁷ and are, therefore, twice as likely as men to contract HIV from unprotected sex with an infected partner.⁸ This medical fact helps explain why heterosexual transmission is the

2. U.N. Programme on HIV/AIDS, Fact Sheet: Women, Girls, Gender Equality, and HIV (2012), http://www.unaids.org/en/media/unaids/contentassets/documents/factsheet/2012/20120217_FS_Women_Girls_en.pdf.

3. Nadine E. Chen, Jaimie P. Meyer & Sandra A. Springer, *Advances in the Prevention of Heterosexual Transmission of HIV/AIDS Among Women in the United States*, 3 *INFECTIOUS DISEASE REP.* 20, 20-21 (2011).

4. See Joseph Prejean et al., *Estimated HIV Incidence in the United States, 2006-2009*, 6 *PLOS ONE* 1, 5-11 tbls. 1-4 (2011).

5. *Id.*

6. HENRY J. KAISER FAMILY FOUND., FACT SHEET: THE HIV/AIDS EPIDEMIC IN THE UNITED STATES (2012), <http://www.kff.org/hiv/aids/upload/3029-12.pdf>.

7. Thomas C. Quinn & Julie Overbaugh, *HIV/AIDS in Women: An Expanding Epidemic*, 308 *SCI.* 1582, 1582-83 (2005).

8. Jennifer Tang & Nawal M. Nour, *HIV and Pregnancy in Resource-Poor Settings*, 3 *REV. OBSTETRICS & GYNECOLOGY* 66, 67 (2010).

primary method of HIV contraction for women.⁹ Young women in particular are at risk, as nearly one-third of girls 14 to 17 reported a condom was not used in their most recent experience of sexual intercourse.¹⁰

With an increased prevalence of HIV in women, and with young women specifically at risk, a number of legal and ethical questions arise about the care these women should receive if they become pregnant. Among the most important of these is how to reduce mother-to-child transmission (MTCT) of HIV. In the last two decades, rates of MTCT of HIV during pregnancy and birth have fallen as a result of the 076 Protocol.¹¹ In this three-step process, physicians administer the antiretroviral zidovudine, or AZT, to the woman at or after fourteen weeks of pregnancy, intravenously during delivery, and to the newborn for six weeks after birth.¹² When combined with elective cesarean section (c-section) deliveries and the absence of breastfeeding, MTCT of HIV falls to less than 2%.¹³ But these and other recommended treatments are lengthy and cumbersome, and not all pregnant women will want or be able to undergo them.¹⁴

In 2005, 92% of children under the age of 13 with AIDS were believed to have acquired HIV from their mother.¹⁵ And while perinatal infections continue to occur across all racial subgroups, the majority of newly infected children are African-American.¹⁶ These outcomes signal that many women are not receiving the kind of pre- and perinatal care necessary to prevent MTCT.

A number of factors are likely in play. First, many patients receive health care from a fractured health care system that does not properly test for HIV, communicate the results to patients, and deliver the information and medical

9. HENRY J. KAISER FAMILY FOUND., FACT SHEET: WOMEN AND HIV/AIDS IN THE UNITED STATES (2012), <http://www.kff.org/hiv/aids/upload/6092-09.pdf>.

10. HENRY J. KAISER FAMILY FOUND., FACT SHEET: SEXUAL HEALTH OF ADOLESCENTS AND YOUNG ADULTS IN THE UNITED STATES (2011), <http://www.kff.org/womenshealth/upload/3040-05-2.pdf>.

11. Edward M. Connor et al., *Reduction of Maternal-Infant Transmission of Human Immunodeficiency Virus Type 1 with Zidovudine Treatment*, 331 NEW ENG. J. MED. 1173 (1994).

12. *Id.* at 1174, 1178. The transmission rate was reduced from 25.5% to 8.3%. *Id.* at 1176. For the purposes of this paper, these rates will be utilized and referred to, using approximations of 25% and 8%. It is also worth noting that the antepartum medication must be taken orally five times a day. *Id.* at 1174.

13. *Achievements in Public Health: Reduction in Perinatal Transmission of HIV Infection—United States, 1985-2005*, 55 MORBIDITY & MORTALITY WKLY. REP. 592, 592 (2006) [hereinafter *Achievements in Public Health*].

14. Another method that is currently used to reduce MTCT is providing nevirapine at delivery and nevirapine syrup to infants after birth. Andrea L. Ciaranello et al., *What Will It Take to Eliminate Pediatric HIV? Reaching WHO Target Rates of Mother-to-Child HIV Transmission in Zimbabwe: A Model-Based Analysis*, 9 PLOS MED. 1, 2 (2012). Also, using a triple-drug antiretroviral (ARV) regimen throughout pregnancy and breastfeeding can lead to the desired reduction in MTCT. *Id.* In this Article, specific treatment methods may be mentioned at certain points, but the general term of “MTCT treatment” may be used as well to refer to any of the drug therapies.

15. *Id.*

16. HENRY J. KAISER FAMILY FOUND., *supra* note 9, at 1.

care required to prevent transmission.¹⁷ In some cases, providers perform routine HIV testing only for pregnant women who fall into a group they consider high risk.¹⁸ Women who are not tested and those who seroconvert during pregnancy are therefore removed from the realm of MTCT treatment options.¹⁹ Meanwhile, evidence suggests that there are significant breakdowns in communication between women with HIV and their physicians with regard to reproductive issues, with many never discussing the possibility of having children.²⁰

Women can also contribute to their susceptibility to these problems by delaying their entry into the health care system.²¹ Fear of stigma and discrimination, barriers to care such as poverty or lack of insurance, and beliefs about their health, medications, and the health care system in general can delay HIV testing and proper care for women, especially minorities.²² This means that HIV-positive women may not seek medical attention until after they are pregnant or show symptoms of the disease.²³ Those accessing care in the later stages of pregnancy can be equally problematic; for example, there is a rising number of teenagers who were perinatally infected and are nonadherent to their treatment regimens who then access care very late.²⁴

There also are various reasons why people living with HIV may decide to delay or avoid conventional therapies, including the long-term effects of treatment, side effects, or faith in alternative treatments.²⁵ And a pregnant woman may have even more anxiety about the drugs she puts into her body.²⁶

17. See Pierre M. Barker, Wendy Mphatswe & Nigel Rollins, *Antiretroviral Drugs in the Cupboard Are Not Enough: The Impact of Health Systems' Performance on Mother to Child Transmission of HIV*, 56 J. ACQUIRED IMMUNE DEFICIENCY SYNDROME e45, e45 (2011).

18. Elijah Paintsil & Warren A. Andiman, *Update on Successes and Challenges Regarding Mother-to-Child Transmission of HIV*, 21 CURRENT OPINION PEDIATRICS 94, 97 (2009).

19. *Id.*

20. Kathleen E. Squires et al., *Health Needs of HIV Infected Women in the United States: Insights from the Women Living Positive Survey*, 25 AIDS PATIENT CARE 279, 279 (2011).

21. See Mariam Aziz & Kimberly Y. Smith, *Challenges and Successes in Linking HIV-Infected Women to Care in the United States*, 52 CLINICAL INFECTIOUS DISEASES S231, S233 (2011) (stating that women are more likely to delay starting treatment than men with HIV).

22. *Id.* at S232-34 (2011). See also Paintsil & Andiman, *supra* note 18, at 95 (discussing the differences in the time of initiation of medication for HIV-positive pregnant women based on race/ethnicity); Squires et al., *supra* note 20, at 283 (finding that HIV-positive women may keep their status confidential as long as possible and may be hesitant to seek medical care for fear of losing their children and likelihood that their children may be ostracized).

23. Aziz & Smith, *supra* note 21, at S232; see also Squires et al., *supra* note 20, at 281 ("[Forty-two percent] of those who were currently pregnant or who had been pregnant were either 'not very aware' or 'not at all aware' of the treatment options for pregnant women with HIV.").

24. Paintsil & Andiman, *supra* note 18, at 97.

25. Kimberly M. Mutcherson, *No Way to Treat a Woman: Creating an Appropriate Standard for Resolving Medical Treatment Disputes Involving HIV-Positive Children*, 25 HARV. WOMEN'S L. J. 221, 238 (2002). Another reason may be a patient's understanding of her inability to stick with the strict medication schedule. *Id.* at n.10.

26. See Karalyn McDonald & Maggie Kirkman, *HIV-Positive Women in Australia Explain Their Use and Non-Use of Antiretroviral Therapy in Preventing Mother to Child Transmission*, 23 AIDS

With the constant advice that pregnant women avoid certain medications, drugs, alcohol, and specific foods, taking treatment to reduce HIV transmission can be psychologically taxing and can cause women to only partially adhere to the recommended regimen.²⁷ Furthermore, a woman may decline MTCT treatment because she has already used the drug therapy unsuccessfully.²⁸ In addition, some research finds that women who are knowledgeable about their condition and are aware of their low viral load may fear that the risk of toxicity is greater than the risk of transmission; it is apparent that the reasons for declining accepted medical treatment are virtually endless.²⁹

The case of an HIV-positive pregnant woman who declines to follow medical advice that would reduce the chance of transmitting HIV to her fetus raises important legal and ethical questions about the fetus that she plans to carry to term. For example, in *Doe v. Division of Youth & Family Services*,³⁰ a woman who was tested for HIV without her consent decided to halt her AZT treatment during pregnancy, refused treatment during delivery, and refused to permit hospital staff to administer the recommended treatment after birth.³¹ For these reasons, the hospital placed the baby in protective custody so that hospital personnel could administer AZT. A court order returned the baby to the mother with mandatory in-home visits to ensure proper administration of treatment.³² When the mother notified hospital personnel that she had ceased the AZT, the baby was again taken from her and the mother was charged with abuse and neglect.³³ The back-and-forth eventually came to an end when the baby tested negative for HIV five-and-a-half months after birth.³⁴

Ultimately, there was no forced medical treatment and this case was not decided on constitutional grounds, but cases concerning the possibility of forcing MTCT treatment upon an HIV-positive pregnant woman certainly would have to address competing interests of the woman and the state. As will be discussed in further detail below,³⁵ the state has a distinct interest in the life

CARE 578, 579 (2011) (discussing the anxiety women felt about the toxicity of treatment and potentially detrimental effects on their babies). See generally Mutcherson, *supra* note 25, at 238 (examining an analogous situation where a woman's child has HIV, and how she is less likely to medicate her child with treatment that she deems inappropriate for herself).

27. McDonald & Kirkman, *supra* note 26, at 580.

28. See generally *In re Nikolas E.*, 720 A.2d 562, 563 (Me. 1998) (providing an example of a woman who refused to provide her son with the recommended HIV treatment because of her experience with HIV therapy and the tragic death of her four-year-old daughter).

29. See McDonald & Kirkman, *supra* note 26, at 581 (finding that even a personal and respectful relationship between a physician and a woman who is educated and experienced with her disease does not ensure compliance with medical recommendations).

30. 148 F. Supp. 2d 462 (D.N.J. 2001).

31. *Id.* at 472.

32. *Id.* at 472-73.

33. *Id.* at 473.

34. *Id.* at 472-73.

35. See *infra* Part II (describing case law establishing a state interest in the fetus).

of a fetus after viability, especially if the woman plans to bring the baby to term. In addition, there is a state interest in the potential costs to society associated with a baby with HIV. Some estimates have placed HIV treatment costs for an adult at approximately \$2,100 per month.³⁶ Medication for infants with HIV typically costs 50-90% more than medication for adults despite using the same agents.³⁷ This can place a substantial burden on the health care system, with the federal government, states, and private insurers already seeing substantial increases in paying HIV-related medical costs.³⁸ Reports say that the cost of HIV care in the United States has increased significantly since the introduction of antiretroviral therapy (ART) and it is expected that the cost will continue to grow.³⁹ Given the high costs of caring for a child born with HIV and that HIV-positive women are disproportionately low-income,⁴⁰ it becomes apparent that the state could end up footing much of the bill.

Cases of forced c-sections, blood transfusions, and other medical interventions for the benefit of the fetus illustrate that forced MTCT treatment is certainly a possibility. This possibility implicates the right to refuse medical treatment, which is a widely recognized constitutional right that should not be overshadowed by the state's interest in a fetus that will ultimately live. Considerations that apply when the fetus will or will not live as a result of the decision are not relevant here.⁴¹ Thus, to focus on case law that trumpets the state's interest in fetal life would be misguided. Moreover, to eschew advances in medication and label HIV a death sentence would only add to the unwarranted stigma the disease still carries.

A decision in the type of case that requires balancing the woman's right to refuse medical treatment and the state's interest in the fetus could have larger implications beyond HIV-positive pregnant women. To tip the scales toward state intervention would ultimately undermine an important right that should be protected, continue to place pregnant women in a class whose rights are not as protected as others, and potentially create a public health problem rather than solve one.

Therefore, this Article seeks to fill the void of constitutional analysis in this type of case. In Part I, the legal foundation of a woman's right to refuse medical treatment is discussed. In Part II, it is juxtaposed against the state's

36. Bruce R. Schackman et al., *The Lifetime Cost of Current Human Immunodeficiency Virus Care in the United States*, 44 MED. CARE 990, 994 (2006).

37. Nicole C. Schmidt et al., *Costs and Benefits of Multidrug, Multidose Antiretroviral Therapy for Prevention of Mother-to-Child Transmission of HIV in the Dominican Republic*, 116 INT'L J. GYNECOLOGY & OBSTETRICS 219, 221 (2012).

38. Schackman et al., *supra* note 36, at 995. With increased costs and longer lifespans, there is also the possibility that lifetime cost caps for insured patients may be reached well before the end of life. *Id.*

39. *Id.*

40. HENRY J. KAISER FAMILY FOUND., *supra* note 9 (demonstrating that nearly two-thirds of women with HIV/AIDS had annual incomes below \$10,000).

41. See *infra* Part III.A (discussing the state interests in fetal life versus fetal health).

interest in the fetus. The state's interests are illustrated through case law concerning abortion, pregnant women refusing other medical procedures, and the authority of the state to protect the public's health. Each of the state interests and their legal underpinnings are analyzed to show that not only are these cases not analogous to the situation in question, but a proper reading of legal and ethical doctrines insists that a court respect the woman's decision. Finally, Part III discusses the state's interests in the potentiality of life versus fetal health, and examines the important policy factors that a court should consider when determining whether to force medical treatment on a pregnant woman on behalf of the state's interests. Unsurprisingly, these policy factors not only indicate that treatment should not be compelled, but suggest that to compel it would create more harm than good.

I. THE WOMAN'S RIGHT TO REFUSE MEDICAL TREATMENT

The right to refuse medical treatment was recognized as a constitutionally protected right in the historic case of *Cruzan v. Director, Missouri Department of Health*.⁴² In this case, the Court recognized that this constitutionally protected liberty was one that had evolved from the right of self-determination, a right established and protected by the common law. In fact, the Court noted that "no right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."⁴³ The Court stated that this right to bodily integrity stemmed from the universally accepted doctrine of informed consent, meaning that every person of adult years and sound mind has a right to decide what will be done with his or her own body.⁴⁴ For if a person can grant informed consent, surely a person also possesses the right not to consent, that is, to refuse medical treatment, as well.⁴⁵

In *Cruzan*, the Court held that the Fourteenth Amendment provided a "constitutionally protected liberty interest in refusing unwanted medical treatment."⁴⁶ The Due Process Clause protects not only a liberty interest in the life of a person, but also an interest in refusing treatment that would help sustain that life.⁴⁷ The legal right to refuse treatment is backed by the essential ethical principle of autonomy, which, at a minimum, protects the right of each person to make voluntary and informed decisions free from interference and

42. 497 U.S. 261 (1990).

43. *Id.* at 269 (internal citations and quotation marks omitted).

44. *Id.*

45. *Id.* at 270.

46. *Id.* at 278.

47. *Id.* at 281.

limitations by others.⁴⁸ Therefore, with informed consent, an individual should be free to decline any medical treatment that she decides she does not want.

However, a person's liberty interest in refusing medical treatment is not absolute. In *Cruzan*, the Court also stated that even when dealing with a person's constitutionally protected liberty interests, a decisionmaker must balance such interests against relevant state interests to determine if a constitutional violation has occurred.⁴⁹ The four interests of the state that may provide a basis for limiting a person's right to refuse medical treatment are: "the preservation of life, the protection of the interests of innocent third parties, the prevention of suicide, and the preservation of the ethical integrity of the medical profession"⁵⁰

In *Washington v. Glucksberg*, the Court utilized these limitations in order to differentiate between allowing a person to die by refusing medical treatment and facilitating someone's death by physician-assisted suicide.⁵¹ Despite the Court finding that the Fourteenth Amendment did not offer a right to physician-assisted suicide, the Court reaffirmed the right to refuse unwanted medical treatment grounded in the Due Process Clause.⁵² The Court found that this right to refuse medical treatment could objectively be categorized as a fundamental right deeply rooted in the tradition and history of the United States and "implicit in the concept of ordered liberty."⁵³ Because this right could be described carefully, it satisfied the second prong of the Court's substantive due process analysis.⁵⁴ This long legal tradition of protecting the right to refuse medical treatment contrasts with physician-assisted suicide, which had never garnered such legal confirmation and, therefore, could not counter the weight of the state's interest in preserving life.⁵⁵

In another case, *Vacco v. Quill*,⁵⁶ the Court again isolated physician-assisted suicide from the protection of the Fourteenth Amendment.⁵⁷ In this case, which focused on the Equal Protection Clause, the Court did not find similarities between terminally ill patients on life support who could hasten death by refusing this medical treatment and those who wished to hasten death

48. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 58 (5th ed. 2001). "To respect an autonomous agent is, at a minimum, to acknowledge that person's right to hold views, to make choices, and to take actions based on personal values and beliefs Respect, on this account, involves acknowledging decision-making rights and enabling persons to act autonomously." *Id.* at 63.

49. *Cruzan*, 497 U.S. at 279.

50. *Id.* at 271.

51. 521 U.S. 702 (1997).

52. *Id.* at 720.

53. *Id.* at 721.

54. *Id.*

55. *Id.* at 725-26.

56. 521 U.S. 793 (1997).

57. *Id.* at 807-08.

by physician-assisted suicide.⁵⁸ Yet the Court made it a point to reassert that every competent individual maintains a right to refuse life-sustaining treatment regardless of physical condition.⁵⁹

This right has been upheld on the state level as well. In *Stamford Hospital v. Vega*,⁶⁰ the Connecticut Supreme Court found that Vega, a Jehovah's witness who had refused a blood transfusion on religious grounds, had had her fundamental right to refuse treatment violated when she was given the procedure in order to save her life.⁶¹ Focusing on the common law right of bodily self-determination, the court found that if this right was to be respected, that respect had to extend even to situations of life and death.⁶² Therefore, given Vega's clear and informed decision to refuse blood even in the face of death, the court found that the trial court and hospital erred in weighing the state's interest in preserving life more heavily.⁶³

In *In re Hughes*,⁶⁴ another case of a Jehovah's Witness refusing blood, the Superior Court of New Jersey held that the woman's rights were not violated only because there was some uncertainty as to her desires given the unexpected gravity of the situation and her husband's initial consent to the transfusion.⁶⁵ The court stated that competent people have every right to refuse medical treatment even to the point of sacrificing their own life as long as it is clear that that is what they truly wish.⁶⁶ Nevertheless, when balancing the state's interest in preserving life against the woman's right to refuse treatment, the court found that there was enough uncertainty due to factors such as the husband providing initial consent and declining to answer the judge when asked if additional blood should be refused to foreclose a clear violation.⁶⁷ Yet again, the court found it important to clearly state that the right to refuse medical treatment is protected not only by the common law, but also by the federal and state constitutions.⁶⁸

In a similar case, *In re Martin*,⁶⁹ the Michigan Supreme Court upheld the right to refuse even life-sustaining treatment for an incompetent person.⁷⁰ The court used a subjective standard, rather than what a reasonable or average person might choose, to effectuate a patient's right to self-determination.⁷¹ The

58. *Id.* at 800.

59. *Id.*

60. 674 A.2d 821 (Conn. 1996).

61. *Id.* at 831.

62. *Id.* at 831-32.

63. *Id.* at 832.

64. 611 A.2d 1148 (N.J. Super. Ct. App. Div. 1992).

65. *Id.* at 1152-53.

66. *Id.* at 1153.

67. *Id.*

68. *Id.* at 1151.

69. 538 N.W.2d 399 (Mich. 1995).

70. *Id.* at 406.

71. *Id.* at 407-08.

court reasoned that the ethical basis of informed consent is rendered meaningless if "after receiving all information necessary to make an informed decision, the patient is forced to choose only from alternative methods of treatment and precluded from foregoing all treatment whatsoever."⁷² In this particular case, the patient was not allowed to refuse treatment because there was not clear and convincing evidence that this would be his decision were he competent.⁷³

However, in two cases concerning prisoners, their right to refuse medical treatment while incarcerated was recognized. In *Thor v. Superior Court*,⁷⁴ a quadriplegic refused medical treatment, which consequently created a substantial risk of death.⁷⁵ The Supreme Court of California held that a patient retains the right to make subjective treatment decisions if she understands the circumstances regardless of the wisdom or rationality of those decisions.⁷⁶ The court did not recognize "an unqualified or undifferentiated policy of preserving life at the expense of personal autonomy," because if self-determination is to have any meaning, "it cannot be subject to the scrutiny of anyone else's conscience or sensibilities."⁷⁷

Thus, despite a prisoner's rights being deprived in other situations, the court held that measures undertaken "must be demonstrably 'reasonable' and 'necessary,'" rather than "a matter of conjecture."⁷⁸ With no overriding state interest, the court could not support forcing on an inmate an unwanted treatment that involved its own substantial surgical procedure, caused discomfort, and created additional risks.⁷⁹ Likewise, the Fourth District Court of Appeal of Florida upheld a prisoner's right to refuse medical treatment in *Singletary v. Costello*.⁸⁰ Despite the fact that the court felt the injunction sought should only be granted sparingly, the prisoner's desire to partake in a hunger strike could not be overcome by forced medical treatment, assistance, testing, or procedure of any form.⁸¹ The state interest in the preservation of life, by itself, "cannot overcome the fundamental" privacy right to refuse unwanted treatment.⁸²

The potential limitations on one's right to refuse medical treatment become more complex when dealing with a maternal/fetal conflict. In particular, the previously discussed compelling state interests in the preservation of life and

72. *Id.* at 405.

73. *Id.* at 413.

74. 855 P.2d 375 (Cal. 1993).

75. *Id.* at 379.

76. *Id.* at 381.

77. *Id.* at 384-85.

78. *Id.* at 388.

79. *Id.* at 384.

80. 665 So.2d 1099 (Fla. Dist. Ct. App. 1996).

81. *Id.* at 1102.

82. *Id.* at 1110.

protection of third parties may limit the right to refuse medical treatment. While a fetus is not recognized as a person under the law,⁸³ subsequent case law has created state interests in the fetus itself that may override the mother's liberty interest in refusing unwanted medical treatment.⁸⁴ As such, these state interests in the fetus must be analyzed more thoroughly to allow a court to properly balance them against the woman's rights and determine which weigh more heavily.

II. DEFINING THE CONTOURS OF A COMPELLING STATE INTEREST

State interests have been found to outweigh the wishes of pregnant women in a variety of cases. While abortion cases may be the most infamous in determining a woman's right to choose, subsequent court decisions related to refusal of blood transfusions and c-sections deemed necessary to save the fetus's life have relied heavily on the state's interest in potential life. With no case law to guide a constitutional analysis of the legal implications presented by an HIV-positive pregnant woman refusing MTCT treatment, it is essential to examine these potentially analogous cases. Yet whether these cases are in fact analogous enough to be persuasive is another issue completely. Since the case of potential HIV transmission deals with an infectious disease, in addition to the state's interest in the fetus there is also a state interest in protecting the public health. Therefore, determining whether an HIV-positive pregnant woman refusing MTCT treatment is an actual public health concern will be an important issue to tackle as well.

A. Abortion Doctrine

To properly weigh the state's interest in protecting a fetus, the abortion case law that demonstrates the evolution of that interest must be properly evaluated. In *Roe v. Wade*,⁸⁵ the Court found that a woman had a fundamental right to privacy that allowed her to choose to have an abortion before viability without interference by the state unless the state's action was reasonably related to the health of the mother.⁸⁶ One of the primary reasons the Court came to this conclusion was its determination that the fetus was not a person in the sense of deserving constitutional protection.⁸⁷ However, the Court also found that the state had a compelling interest in protecting the potentiality of

83. *Roe v. Wade*, 410 U.S. 113, 158 (1973).

84. See *infra* Part II (discussing the state's interests in the fetus that have developed from abortion case law as well as from maternal-fetal conflict cases).

85. 410 U.S. 113.

86. *Id.* at 164.

87. *Id.* at 158.

human life after viability and, therefore, was free to regulate or even prohibit abortions after this stage.⁸⁸ However, any restrictions placed on abortions after viability needed to contain exceptions for the health of the woman.⁸⁹

Although the *Roe* Court found no state interest in the health of the mother during the first trimester of pregnancy,⁹⁰ the Court in *Planned Parenthood of Southeastern Pennsylvania v. Casey*⁹¹ held that the state's interest in the fetus is substantial at conception and becomes a compelling interest after the point of viability.⁹² Before viability, a state could regulate pregnancy in a manner that demonstrated its respect for life as long as such regulation was not a substantial obstacle that placed an undue burden on the woman's right to choose an abortion.⁹³ However, this concern was not as important once the pregnancy reached the point of viability and the state's interest transitioned from legitimate to compelling. This reasoning of *Casey* indicates that the right of an HIV-positive woman to refuse MTCT treatment will likely be weighed against a compelling state interest in the potential life of the fetus.⁹⁴ Nevertheless, it is unclear how this holding creates a compelling state interest in the potential health of the newborn.⁹⁵

The Court in *Gonzalez v. Carhart*,⁹⁶ dealing with partial-birth abortion bans, made it a point to reiterate the *Casey* Court's view that the state has the authority to regulate according to its profound interest in potential life.⁹⁷ In furthering this interest, the state may bar certain procedures and substitute others that it feels demonstrate respect for the potential life when there is a rational basis for action.⁹⁸ Within this respect for human life, the Court found that there lies a "bond of love the mother has for her child," which can lead some women to later regret their decision to have an abortion.⁹⁹ Despite finding "no reliable data to measure the phenomenon," the Court used the issue of regret as another justification to find a state interest.¹⁰⁰ Moving further from *Roe*, the Court here appears to focus much less on issues of privacy and the doctor-patient relationship. Instead, a state interest stems from not only the potentiality of life, but also the regret a woman might have and the societal interest in prohibiting a medical procedure that Congress and the Court felt

88. *Id.* at 164-65.

89. *Id.*

90. *Id.* at 163.

91. 505 U.S. 833 (1992).

92. *Id.* at 878-79.

93. *Id.*

94. *Id.* at 879.

95. See *infra* Part III.A (finding that abortion case law does not create a compelling state interest in the health of the fetus).

96. 550 U.S. 124 (2007).

97. *Id.* at 157.

98. *Id.* at 158.

99. *Id.* at 159.

100. *Id.* at 159-60.

may “coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life.”¹⁰¹

In the circumstance of an HIV-positive pregnant woman refusing MTCT treatment, the issue of abortion does not arise and, thus, much of the abortion case law’s discussion of the importance of life is inconsequential. In this circumstance, the mother does not plan to terminate her pregnancy and fully intends to have a child. It would be irresponsible for a court to force MTCT treatment by analogizing the potential of contracting HIV to a fetal termination. Not only has the pregnant mother chosen to keep her fetus, but due to medical advances the child has the opportunity to live a relatively healthy life.¹⁰² However, the abortion cases still have important implications.

The holding that a fetus is not a person has yet to be overturned by any subsequent cases and, therefore, the interests of the fetus cannot be described in terms of the constitutional rights of a human being. While *Casey* finds a compelling state interest at the point of viability, the Court also states that the “destiny of a woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.”¹⁰³ In light of this statement, refusal of treatment implicates a conflict between the rights of the woman and the interests of the state.

The *Carhart* decision seems to indicate that this right to shape one’s destiny must also factor into what society may judge to be unsavory decisions for a pregnant woman. Large segments of society may find the notion of a mother refusing MTCT treatment disconcerting, if not worse. While the chance of transmission itself may not be disturbing, refusing a well-proven treatment program that can virtually eliminate the chance of transmission may prove too much for some to countenance. It is unclear whether this refusal would constitute a “gruesome and inhumane procedure.”¹⁰⁴ In fact, to reduce the chances of transmission from approximately 25% to less than 2%, more is required than the medical treatment administered during pregnancy.¹⁰⁵ It is possible that significant interventions—c-section, avoiding breastfeeding, and postnatal treatment—could be utilized independently in order to reduce the chance of the newborn becoming HIV-positive.¹⁰⁶

101. *Id.* at 157.

102. See Mutcherson, *supra* note 25, at 236 (stating that if all goes well with a child’s medication regimen, the child will experience minimal side effects, if any, and an undetectable viral load).

103. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1992).

104. *Carhart*, 550 U.S. at 141.

105. The original drug treatment plan alone was found to reduce the transmission rate to nearly 8%. Connor et al., *supra* note 11, at 1176. The use of a c-section delivery, eliminating breastfeeding, and postnatal treatment reduced the transmission rate to under 2%. *Achievements in Public Health*, *supra* note 13.

106. With a standard of care that is known to be effective already determined, it is difficult, if not impossible, to ethically justify clinical trials determining the success of utilizing only certain parts of that standard.

In considering the Court's concern over a woman's potential regret, it is conceivable that another court may find that a woman who wishes to give birth and raise a child may be just as likely to regret her decision if it ultimately caused her child to contract a potentially deadly disease.¹⁰⁷ However, a pregnant woman who knows that she is HIV-positive may understand the risks of transmission and the type of life her child would have if the child were to contract the disease. Moreover, in terms of the state's interest, this is not the life-and-death decision that accompanies an abortion. A state interest in the potentiality of life should not justify governmental compulsion for a fetus that will ultimately live simply out of concern over regret. The advances made in HIV treatment, which allow for the possibility of a long and healthy life if treatment plans are followed appropriately,¹⁰⁸ should make it difficult for a court to force treatment to reduce the chance of HIV transmission simply due to concerns over a mother's potential regret.

Even a concern about coarsening society¹⁰⁹ should not be seen as providing justification for forced MTCT treatment. Otherwise, it opens the door for courts to impose moral judgments on citizens. In the case of an HIV-positive pregnant woman, compelling treatment may actually further stigma and inaccurate understanding of the disease, arguably coarsening society to those who are HIV-positive.

B. Compelled Medical Treatment Jurisprudence

If a court considers forcing MTCT treatment, it will look to why courts have justified forcing pregnant women to undergo unwanted medical treatments in the past. Despite the fact that a c-section is a major surgery that has significant risks, courts have found it necessary to order women to undergo the procedure against their will in certain circumstances. In *Jefferson v. Griffin Spalding County Hospital Authority*,¹¹⁰ the Supreme Court of Georgia held that a viable unborn child had a right to state protection under the U.S. Constitution and, as such, this viable fetus's right to life outweighed the intrusion of giving a pregnant woman an unwanted c-section and any necessary blood transfusions.¹¹¹ Physicians testified that if natural childbirth were attempted, the fetus had a 99% chance of death, and the mother's chance of surviving was no better than 50%, whereas both had a nearly 100% chance of survival with a

107. See Margo Kaplan, "A Special Class of Persons": Pregnant Women's Right to Refuse Medical Treatment After *Gonzales v. Carhart*, 13 U. PA. J. CONST. L. 145, 177 (2010) (discussing the possibility that a chronic disease may raise moral issues at least as serious as the choice of an intact dilation and evacuation procedure over another abortion method).

108. Mutcherson, *supra* note 25, at 236.

109. See *supra* note 101 and accompanying text.

110. 274 S.E.2d 457 (Ga. 1981).

111. *Id.* at 458-60.

c-section.¹¹² Therefore, the court ordered that if the woman came to the hospital seeking emergency delivery services, the hospital was to take custody of the fetus and perform any services deemed necessary to save the life of that fetus.¹¹³ In this case, the “inseparable” nature of the lives of the mother and fetus meant that the state interest in protecting the potential life was invariably intertwined with saving the mother’s life as well.¹¹⁴ On the other hand, refusing MTCT treatment does not present an analogous scenario of two lives fixed together and both in danger.

Despite the fact that the *Jefferson* court found the state interest in the life of the fetus to warrant unwanted intervention, it is important to note that the court denied a request to order the woman to return to the hospital and submit to the surgery prior to the start of the natural labor.¹¹⁵ With a compelling state interest and the mother’s rights outweighed, the court refused to compel treatment.¹¹⁶ Instead, the court opted to wait for the woman to return voluntarily to the hospital and once services had been rendered, the hospital was deemed to be within its right to perform the procedures it felt were necessary to ensure the fetus’s survival.¹¹⁷ If a court is unwilling to take a woman into custody and force treatment when fetal life is potentially in jeopardy, it seems that a court would be even more unwilling to do so when there is no life hanging in the balance.

The District Court in *Pemberton v. Tallahassee Memorial Regional Medical Center*¹¹⁸ did not adopt this approach. After a woman seeking intravenous fluids refused to undergo the c-section the hospital had advised, she returned home to complete her natural home birth.¹¹⁹ Yet, the court held that because labor had begun, the state’s interest in the fetus clearly outweighed any constitutional right to refuse treatment and, thus, ordered law enforcement to retrieve the woman from her house and to return her to the hospital.¹²⁰ Relying on the abortion case law, the court reasoned that if a woman can be forced to bear a child she does not want because it has reached viability, then it is less of an imposition to require one method of birth over another.¹²¹ As such, it seems that the court felt the woman’s desire to deliver the child actually strengthened the case for intervention and supported state action. While the facts and issues were similar to a case where an HIV-positive

112. *Id.* at 458.

113. *Id.* at 460.

114. *Id.* at 458.

115. *Id.*

116. *Id.* at 460.

117. *Id.*

118. 66 F. Supp. 2d 1247 (N.D. Fla. 1999).

119. *Id.* at 1249.

120. *Id.* at 1250-51.

121. *Id.* at 1251-52.

woman wishes to deliver her child without MTCT treatment, the *Pemberton* court relied on the state's consideration of a "baby's interest in living," entangling it with the state interest in life, to outweigh the mother's interest in resisting the procedure.¹²²

Although the rationale of the *Pemberton* court may not be as troubling as that found in *Jefferson*, the actions taken give ample reason for concern. Not only was the mother forced to undergo invasive surgery that had substantial risks for her, but was also physically forced from her home in order to be subjected to this procedure. The implications of courts ordering women taken from their home against their will and being forced to undergo treatment they have refused could have damaging effects on women's trust in hospitals, physicians, and the courts.¹²³ Moreover, this order came down in spite of the fact that the risks associated with natural birth were uncertain at best. Varying testimony placed the risk of uterine rupture from natural birth, which itself is not certain to produce fetal death, at anywhere from 2% to 60%. Nevertheless, the court held that "regardless of whether the actual risk of the baby's death was one percent or six percent or sixty percent, the risk was substantial."¹²⁴ To apply this approach regarding the risk of death to the possibility of transmitting HIV would be inaccurate and could have potentially damaging effects. The possibility that a newborn acquires HIV because the mother refuses medical treatment and the potential for death from refusing a c-section are not the same. To treat them as such is misleading and harms efforts to educate the public on HIV and its effects.¹²⁵

The *Jefferson* and *Pemberton* courts claim to balance the woman's interest against that of the state. Yet the reasoning used seems to imply that once viability has been reached, the woman's interest can almost always be outweighed.¹²⁶ This clear lack of respect for a woman's autonomy disregards the judicial recognition of constitutional liberty interests, which may be limited

122. *Id.* at 1252.

123. See *In re A.C.*, 573 A.2d 1235, 1248 (D.C. Cir. 1990) (finding that court-ordered c-sections erode the trust between a pregnant woman and her physician while driving women at high risk of complications during pregnancy and childbirth out of the health care system in hopes of avoiding coerced treatment (citing Brief for American Public Health Association as Amici Curiae Supporting Appellant, *In re A.C.*, 573 A.2d 1235 (D.C. Cir. 1990) (No. 87-609))). See *infra* Part III.B (discussing the public health implications of compelling treatment of HIV-positive pregnant women in more depth).

124. *Pemberton*, 66 F. Supp. 2d at 1257.

125. See *infra* Part III.B (describing the effects on stigma and HIV education this type of ruling could have).

126. This logic appears to follow the language from *Casey* that "a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child." *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 870 (1992). However, not only does this language imply that it is merely a theory and not a holding, it is in the context of abortion, rather than medical decision-making. Additionally, refusing treatment that would reduce the risk of transmitting HIV presents no risk of death to the fetus. See *infra* Part III.A (discussing the difference in the state's interest in the life of the fetus and the health of the fetus).

in certain circumstances but not completely extinguished at viability. This recognition of a woman's rights can be found more adequately discussed in *In re A.C.*,¹²⁷ where a woman dying of cancer had consented to a c-section at twenty-eight weeks but the procedure was performed at twenty-six and one-half weeks when she became severely ill.¹²⁸ While this case is not about refused medical treatment because the woman consented to the same procedure for the specific purpose of saving the fetus, the Court of Appeals for the District of Columbia felt that conducting the c-section one and one-half weeks early required a new expression of consent out of respect for her right to autonomy.¹²⁹ Since the woman was too heavily sedated for the hospital to be certain of her wishes, the court still felt that her choices must be followed and, therefore, substituted judgment must be utilized to ascertain what her decision would have been.¹³⁰ So while this woman did not refuse treatment, thereby not necessarily defying what may be seen as morally right, the court did emphasize that only in extremely rare circumstances should a court override a woman's decision to forgo major surgery such as a c-section.¹³¹

This is a position that the Appellate Court of Illinois supported in *In re Baby Boy Doe*,¹³² which determined that c-sections present harms to a woman's health and are too invasive to allow her refusal to be overridden by whatever rights a fetus may have.¹³³ In fact, the *Baby Boy Doe* court felt decisions coming to a contrary conclusion, including the *Jefferson* decision, did not properly weigh the magnitude of the right to refuse treatment.¹³⁴ The *Baby Boy Doe* court emphasized that creating additional risks to the woman by forcing her to undergo c-section surgery was in direct opposition to her constitutional rights to refuse unwanted medical treatment.¹³⁵

The *A.C.* court thought it would be prudent to issue an opinion despite the death of both the fetus and mother in hopes that it would guide courts in future situations where a woman is either incapable of consenting to treatment or refuses treatment.¹³⁶ The *A.C.* court's contention that no one should be compelled to save a fetus because no person may be compelled to save another

127. See *A.C.*, 573 A.2d at 1243-44 (examining the legal history of a person's right to refuse medical treatment and disagreeing with the notion that a fetus could have rights superior to those of a person who has already been born).

128. *Id.* at 1238.

129. *Id.* at 1237 (stating that the patient has the right to decide what is to be done to them in virtually all cases).

130. *Id.* at 1237, 1239.

131. *Id.* at 1252.

132. 632 N.E.2d 326 (Ill. App. Ct. 1994).

133. *Id.* at 330.

134. *Id.* at 332-33 (including the *Jefferson* court in the discussion of courts lacking a recognition of the constitutional dimension of the right to refuse treatment).

135. *Id.* at 333 ("it appears that a forced cesarean section undertaken for the benefit of the fetus, cannot pass constitutional muster").

136. See *A.C.*, 573 A.2d at 1242.

living person¹³⁷ should be strongly considered in the case of an HIV-positive pregnant woman's refusal to submit to MTCT treatment. It would be problematic for courts to insist that a fetus, which is not legally recognized as a person, should have rights "superior to those of a person who has already been born."¹³⁸ However, the *A.C.* court felt no need to address whether "lesser invasions," such as blood transfusions, may be permitted,¹³⁹ a stance the *Baby Boy Doe* court again chose to follow.¹⁴⁰

Whereas the *Baby Boy Doe* court felt that a blood transfusion was a "relatively non-invasive and risk-free procedure,"¹⁴¹ the court in *In re Fetus Brown* found the procedure invasive enough to unconstitutionally violate a person's bodily integrity.¹⁴² In balancing the rights of the woman with the interests of the state, the court felt it was unable to impose a legal obligation on a pregnant woman to consent to an unwanted medical procedure.¹⁴³ The court found state interests in protecting the autonomy of the individual and in preserving and promoting one's liberty interest,¹⁴⁴ state interests that appear to be left out of the balancing equation quite frequently. Additionally, the court questioned the prudence of enforcing these court orders.¹⁴⁵ For example, the woman in *Brown* tried to resist the transfusion and consequently was "yelled at and forcibly restrained, overpowered and sedated."¹⁴⁶ Perhaps a more practical method of enforcement, a contempt citation for refusing to adhere to an injunction requiring the mother to consent, would compel compliance by imposing a fine, imprisonment, or another sanction.¹⁴⁷ Again, the court questions the "efficacy of a court order requiring a blood transfusion for someone who is facing death,"¹⁴⁸ illustrating the failure of such orders to actually accomplish the goal of forcing the refused treatment.

The practicalities of enforcing a court order to undergo treatment to prevent HIV transmission also present clear legal and ethical concerns. A full treatment schedule must be strictly adhered to over months, and there is a chance that this may only be accomplished by physical force or its equivalent. While major surgery such as a c-section may be more of a direct invasion into one's bodily integrity, forced treatment could create a continuous invasion over weeks due to the necessity of a lengthy medication regimen. Although each

137. *Id.* at 1243-44.

138. *Id.* at 1244.

139. *Id.* at 1246 n.10.

140. *See Baby Boy Doe*, 632 N.E.2d at 333.

141. *Id.*

142. 689 N.E.2d 397, 405 (Ill. App. Ct. 1997).

143. *Id.*

144. *Id.* at 403.

145. *Id.* at 405.

146. *See id.* at 400.

147. *Id.* at 405-06.

148. *Id.* at 406.

individual invasion may not prove quite as serious as a c-section, the continuous series of bodily invasions over a prolonged period of time may cumulatively create a great violation of autonomy. The potential need to fasten a woman down and forcibly drug her should “surely give one pause in a civilized society.”¹⁴⁹ Given the forced c-section cases described earlier, one can foresee the scenario of an HIV-positive pregnant woman who has taken no medication to reduce transmission entering a hospital to give birth and the staff requesting a c-section as a last-minute effort to reduce the possibility of the child being born with HIV.¹⁵⁰

Another factor distinguishing a forced drug regimen from that of a c-section or blood transfusion is the effect on the woman. In situations where the pregnant woman’s life is threatened by refusing a c-section or blood transfusion, the state’s interest in protecting the potential life of the fetus coincides with the state’s interest in preserving the life of the woman from possible death. Conversely, current drug treatments to prevent HIV transmission not only are unnecessary to save the life of the fetus, but they are also not necessarily beneficial to the pregnant woman either. For example, AZT treatment can have risks and side effects that range from unpleasant to life-threatening.¹⁵¹ Possible complications include “nausea; vomiting; diarrhea; a painful and potentially debilitating condition called neuropathy that causes pain in the hands and feet; impaired functioning of vital organs such as the liver and kidneys; bone marrow suppression; damage to the reproductive system; and increased risk of heart disease.”¹⁵² A number of women that took AZT have also experienced hair loss and vomiting blood.¹⁵³ Moreover, a woman with a low viral load may find little to no personal benefit in taking ARVs to reduce the likelihood of transmission.¹⁵⁴ Therefore, the claim that MTCT treatment poses little to no risk to a pregnant woman and may even be beneficial is simply untrue. Not only do the side effects present the possibility of substantial harm, there is a risk that the woman may develop some resistance to HIV medications, which may reduce her own treatment options and potentially shorten her life.¹⁵⁵ If the state interest in preventing the fetus from acquiring HIV were taken to its extreme, a court ordered c-section would also

149. *In re A.C.*, 573 A.2d 1233, 1244 n.8 (D.C. Cir. 1990). See also *In re Baby Boy Doe*, 632 N.E.2d 326, 330 (Ill. App. Ct. 1994) (discussing that although the state requested the court order for the c-section, they opposed the use of force).

150. This scenario should still be more difficult for a court to enforce than the previous c-section cases due to the lack of a threat to the child’s life. See *infra* Part III.A (distinguishing the state’s interest in the life of the fetus from its interest in the health of the fetus).

151. Kaplan, *supra* note 107, at 185.

152. *Id.*

153. Mutcherson, *supra* note 25, at 263.

154. McDonald & Kirkman, *supra* note 26, at 581 (describing a woman who knew her viral load was low and refused ARVs during her pregnancy).

155. Kaplan, *supra* note 107, at 185.

hold substantial risks to the woman, given the fact that it is a major and highly invasive surgical procedure. These potential harms may result in diminished health and possibly a shorter life for the mother, which create risks for the newborn by impacting the mother's ability to fully care for the child.

Furthermore, the type of harm to the fetus distinguishes the case of refused MTCT treatment from the life-and-death scenarios found in the c-section and blood transfusion cases. Additionally, a reduction in the chance of transmission from approximately 25% can hardly be analogized to the 99%-certainty-of-death situations found in the previous cases.¹⁵⁶ In the case of refusing MTCT treatment, the potential danger is not immediate death, but rather the contraction of a chronic illness. Also, the mother's decision is not directly linked to a near certainty of this consequence. While 25% is high, especially compared to the potential to reduce it to less than 2%, a one in four chance of disease transmission does not begin to approach the severity of a 99% chance of death.

C. Protecting Public Health

The government has the primary responsibility to protect the public's health, and the entire population has a justifiable expectation that public health services will be used for its benefit.¹⁵⁷ This inherent duty can be found in the state's police power and *parens patriae* power.¹⁵⁸ With this responsibility comes the need to potentially coerce individuals to act in a manner that prevents putting others at risk of harm. History shows that the government is

156. Connor et al., *supra* note 11, at 1176. This is assuming that a court would be reluctant to order the necessary procedure of a c-section and prohibit breastfeeding by force, which would drop the chance of transmission to less than 2%. *Achievements in Public Health*, *supra* note 13, at 592. Given the lack of a life or death scenario, it would be an egregious disregard of a woman's bodily integrity to subject her to major surgery in the hopes of reducing the chance of a child being born with what appears to be a growingly manageable disease.

157. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 6 (2008).

158. *Id.* at 79-80. While the *parens patriae* power is one of the tools with which the government can protect the public's health, it seems unlikely that it would be relevant to the scenario discussed in this paper. Typically, the *parens patriae* power is used to protect persons under legal disability, such as minors or incompetent persons. *Id.* at 95-96. Since the fetus is not recognized as a person, this exercise of power would not qualify. See *Roe v. Wade*, 410 U.S. 113, 158 (1973) (observing that "the word 'person,' as used in the Fourteenth Amendment, does not include the unborn"). The *parens patriae* power can also be used to assert the state's general interest in the community's health, however, this application of authority gives the state standing to sue in court to promote communal interests and protect the interests of its citizens. GOSTIN, *supra* note 157, at 98. In either circumstance where the state is using its *parens patriae* power, the ultimate objective is to protect individuals who cannot protect themselves. *Id.* at 98. Because the court does not recognize the fetus as a person, it seems unlikely that the state would be able to assert the *parens patriae* power on behalf of the fetus. While there are cases that have asserted *parens patriae* power to protect the interests of the fetus, these cases directly disregard Supreme Court precedent by ignoring the distinctions made between a fetus and a child. See April L. Cherry, *The Free Exercise Rights of Pregnant Women Who Refuse Medical Treatment*, 69 TENN. L. REV. 563, 598 (2002).

not opposed to controlling individuals and restricting their rights in order to safeguard the public's health.¹⁵⁹ However, these governmental actions must be done in accordance with the framework of the Constitution.¹⁶⁰ It is vital to appropriately balance the state's authority and duty to protect the public health with respect for protected individual rights when determining proper action in critical health matters. In terms of state intervention on behalf of a fetus, the question is not what the state must do to protect the public's health, but rather what they are authorized to do in this circumstance.

1. The Force of Police Power

The police power is the "inherent authority of the state . . . to enact laws and promulgate regulations to protect, preserve, and promote the health, safety, morals, and general welfare of the people."¹⁶¹ The police power is an authority that the state commonly uses in order to restrict private interests for the public good. The police power can justify interference with autonomy, privacy, association, and liberty.¹⁶² In terms of public health, state action normally is aimed at improving population morbidity and mortality, either directly or indirectly.¹⁶³ While the state retains discretion to decide what is injurious or unhealthy and to select its manner of regulation, its actions must still be confined by the constitutional protections of personal interests.¹⁶⁴

Judicial recognition of police power and of the state's ability to impinge on individual rights in certain contexts can be found in *Jacobson v. Massachusetts*.¹⁶⁵ Upholding state authority to pass compulsory vaccination laws, the Court held that no person had an absolute right to be free from restraint because the government was instituted "for the protection, safety, prosperity and happiness of the people, and not for the profit, honor, or private interests of any one man"¹⁶⁶

The types of restraints or sacrifices that a person may be asked to make for the greater good fall along a spectrum of slight inconveniences to substantial restrictions on individual liberty. While fluoridation of water is only slightly intrusive, given the fact that a person can alter the water or not drink it,¹⁶⁷ requiring someone to wear a helmet is a moderate inconvenience, and is justified under police powers, with one of its primary rationales being the

159. GOSTIN, *supra* note 157, at 10-11.

160. *Id.* at 11.

161. *Id.* at 91-92.

162. *Id.* at 91, 94.

163. *Id.* at 94.

164. *Id.*

165. 197 U.S. 11 (1905).

166. *Id.* at 26-27.

167. *Quiles v. City of Boynton Beach*, 802 So. 2d 397, 399 (Fla. Dist. Ct. App. 2001).

reduction of health care costs to society for motorcycle accidents.¹⁶⁸ The police power can also be cited as authorization for more stringent restrictions on personal liberty, such as in the case of compulsory vaccinations,¹⁶⁹ quarantine and isolation,¹⁷⁰ and even forced medical treatment.¹⁷¹

2. No Reasonable Action

Having established judicial recognition of state authority to protect the public health through the police power, the next question is whether the case of an HIV-positive pregnant woman refusing MTCT treatment represents a legitimate public health concern that outweighs individual rights. While the Court in *Jacobson* upheld the constitutionality of compulsory vaccinations, the Court was also quick to insist that police powers must be based on the necessity of the case and that the asserted authority cannot be arbitrary or unreasonable or go beyond what is reasonably required for the safety of the public.¹⁷² The Court went on to adopt a means-ends test that required a reasonable relationship between the public health intervention and a legitimate public health goal.¹⁷³ In light of this test, the issue is to determine whether an HIV-positive pregnant woman who refuses MTCT treatment is actually a legitimate public health concern and, if so, whether forced treatment qualifies as a reasonable response to the threat.

In *Jacobson*, the Court found that the legislature was well within its authority to mandate vaccinations in order to prevent the spread of contagious diseases.¹⁷⁴ HIV is a disease transmitted from one person to another, but it does not present the same type of contagious risk to the public as smallpox, the disease in question in *Jacobson*.¹⁷⁵ Other courts have upheld compulsory physical examination and treatment of persons with less serious infectious diseases, yet these diseases frequently look more like smallpox than HIV. In *City of New York v. Antoinette R.*, for example, the court found an order forcing

168. *Benning v. State*, 641 A.2d 757, 762 (Vt. 1994).

169. *See Jacobson*, 197 U.S. at 35.

170. *See Compagnie Francaise de Navigation a Vapeur v. La. State Bd. of Health*, 186 U.S. 380, 387 (1902).

171. Arguably, one of the most egregious invasions of personal liberty can be found when the government involuntarily administers medication. *See Sell v. United States*, 539 U.S. 166, 179 (2003) (upholding the constitutionality of forced administration of antipsychotic drugs to render a mentally ill defendant competent to stand trial, as long as the treatment is medically appropriate, substantially unlikely to have side effects that may undermine the trial's fairness, and is the least intrusive means to further a significantly important state interest).

172. *Jacobson*, 197 U.S. at 28.

173. *Id.* at 31-32.

174. *Id.* at 35.

175. *See, e.g., Boone v. Boozman*, 217 F. Supp. 2d 938, 954 (E.D. Ark. 2002) (discussing the airborne nature of smallpox as compared to Hepatitis B, which can be spread by bodily fluids and surfaces such as door knobs for up to a month).

hospitalization appropriate because the patient had active, infectious tuberculosis (TB).¹⁷⁶ Moreover, the forced detention was authorized by the court not only because of the patient's extremely contagious disease, but also because there was clear and convincing evidence of the patient's inability to comply with her prescribed medication.¹⁷⁷ As such, the risk included the spread of a highly communicable disease, and the potential to create a drug-resistant strain of TB, which would pose an even greater threat to the community.

The risk of a woman transmitting HIV to her fetus seems to fall far short of the dangers to the public presented in the traditional cases upholding the use of police power. This is not to insinuate that the potential of a child being born with HIV does not raise concerns. Rather, it suggests that this potential transmission to one entity is distinct from cases that pose a threat to the public at large. A more attenuated argument is that a child born with HIV poses a threat to eventually spread the infection to others, which makes the seemingly one-to-one transmission more of a public health concern. However, the 25% chance that a woman transmits HIV to her fetus is nowhere near a certainty. If the child is in fact born with HIV, the threat then becomes whether the child will grow up and engage in activities such as unprotected sex or needle sharing that would put others at risk. The likelihood that all of this would come to fruition makes for an extremely small chance that an essentially non-life-threatening disease would spread to a relatively small amount of people. This type of risk does not appear to reach the threshold courts have previously set in order for the state to utilize the police power.

Another manner in which MTCT of HIV could affect public health is through costs. As seen with helmet laws, impositions on personal liberty can be made if the actions of some are greatly increasing health care costs and diverting resources from other essential public health services.¹⁷⁸ A significant proportion of women with HIV have low socioeconomic status and, therefore, may not be able to afford the medication needed to raise a healthy HIV-positive child effectively.¹⁷⁹ The costs associated with raising an HIV-positive child are extremely high, and with such a large number of HIV-positive women in poverty, there is a strong likelihood that the public would cover a substantial amount, if not all, of the costs.

Despite the apparent similarity of costs to society between motorcycle accidents and poor people with HIV, the remedy the state would enforce in

176. See *City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008, 1012 (Sup. Ct. 1995).

177. *Id.* at 1011-12.

178. See *Benning v. State*, 641 A.2d 757, 762 (Vt. 1994) (discussing the relevance of public costs being linked to the actions of others in determining whether police powers were utilized appropriately).

179. See *Mutcherson*, *supra* note 25, at 240 (finding that a majority of HIV-positive women are poor).

each circumstance clearly distinguishes the two.¹⁸⁰ Being asked to wear a helmet or risk being fined is different from being forced to undergo unwanted medical treatment. This distinction becomes more important considering the fact that a public health regulation is unconstitutional if the burden suffered is disproportionate to the expected benefit.¹⁸¹ It is important that the personal invasion be balanced with the public good in order to ensure there is not an unreasonable breach of autonomy.¹⁸² This is particularly true in cases where the state is actually forcing treatment rather than simply compelling treatment.

Compulsory vaccinations are a clear example of this. Despite being one of the most cost-effective and widely used public health interventions, which has essentially eradicated several diseases and substantially decreased child morbidity and mortality, states compel vaccinations only indirectly.¹⁸³ States impose penalties, deny school admission, or, at worst, quarantine an individual who chooses not to be vaccinated.¹⁸⁴ Furthermore, states often allow religious and personal exemptions, which certainly cannot be said to promote the public's health.¹⁸⁵ This demonstrates that, despite their effectiveness and clear benefits to the public, vaccinations are neither forced nor required in all circumstances.

Forced treatment, or at least confinement in order to compel treatment, can be found in other circumstances. The typical standard is that the subject must actually pose a threat to the community and that the risk must be a demonstrable health threat.¹⁸⁶ Whereas the concept of what qualifies as posing an actual threat has evolved from the smallpox threat in *Jacobson*, the theory behind it has essentially remained the same. The requirement of a demonstrable threat exists in order to avoid governmental exercise of compulsory power in a manner that is arbitrary or unreasonable. Moreover, this requirement ensures that the government utilizes such power only when necessary for the safety of the public.¹⁸⁷

Examples can be found in treatments with antipsychotic drugs and in cases of TB. For a person who is seriously mentally ill, courts have allowed compelled treatment when the person poses a danger to themselves or others, the treatment is in the person's best interest, and drugs are administered in accordance with standard medical care by a physician.¹⁸⁸ An HIV-positive

180. A court would stretch the notions of reality if it equated a helmet requirement with forced MTCT treatment. Therefore, this argument of public health costs seems unlikely to be raised.

181. GOSTIN, *supra* note 157, at 127.

182. *Id.*

183. *Id.* at 123, 376.

184. *Id.* at 123.

185. *Id.* at 378-80.

186. *Id.* at 127.

187. See *Jacobson v. Massachusetts*, 197 U.S. 11, 28 (1905).

188. *Washington v. Harper*, 494 U.S. 210, 222-23 (1990).

pregnant woman cannot be accurately described as posing a danger to herself such that medication would be forced on her were she not pregnant. The woman can only be thought of as posing a potential threat to her fetus.¹⁸⁹

Similarly, the case of an HIV-positive pregnant woman refusing treatment is distinct from that of a highly contagious TB patient. For uncooperative TB patients, the state may direct the use of directly observed therapy (DOT),¹⁹⁰ quarantine,¹⁹¹ or isolation.¹⁹² However, only persons who pose a significant risk of transmission may be confined, with isolation typically authorized based on disease status alone or because of risky behavior by infected persons.¹⁹³ Courts ordinarily demand that compelled treatment be “reasonably necessary to safeguard the population,” given the obvious intrusion on bodily integrity.¹⁹⁴ As stated previously, the risk to the population at large from a woman refusing MTCT treatment seems tenuous, and the gravity of the intrusion seems to outweigh the potential benefit of reducing the risk of a one-to-one HIV transmission from approximately 25% to less than 2%.

As the HIV-positive pregnant woman poses little to no threat to the public’s health, with the most likely harm being potential costs to the public, forced MTCT treatment does not appear to fall within the scope of the state’s police powers. While the police power has been used in cases involving sexually transmitted infections,¹⁹⁵ an HIV-positive pregnant woman with no clear goal of having unprotected sex with multiple partners is distinctly different. Additionally, the intervention utilized in the compelled treatment cases is not supposed to pose any risk of harm to the patient.¹⁹⁶ The potential side effects of AZT treatment, for example, constitute a tangible possibility of harm to the woman.¹⁹⁷ Under these circumstances, the authority of the state to protect the public’s health seems to provide unsustainable grounds for the compelled MTCT treatment of an HIV-positive pregnant woman. In reality,

189. Potential threat is more appropriate, given the fact that there is a 25% chance of her transmitting the disease to her fetus, which means there is a 75% chance that she does not. Connor et al., *supra* note 11, at 1176. Moreover, the threat is one of a chronic disease, not a threat of death.

190. DOT is a compliance-enhancing mechanism where a family member, peer advocate, community worker, or health care professional observes each dose of medication. GOSTIN, *supra* note 157, at 415-16.

191. Quarantine is the restriction of people’s movement when they have been exposed, or potentially exposed, to infectious disease during its period of communicability, to prevent transmission of infection during the incubation period. *Id.* at 429 (quoting CONTROL OF COMMUNICABLE DISEASES MANUAL 621 (American Public Health Assoc., David L. Heymann ed., 18th ed. 2004)).

192. Isolation is the separation of people known to be infected in order to prevent or to limit transmission during the period of communicability. *Id.*

193. *Id.* at 444.

194. *Id.* at 412.

195. *See id.* (“[M]ost STI and TB laws, for example, grant the power to compel physical examination and medical treatment.”).

196. *Id.* at 127-28.

197. *See supra* notes 151-155 and accompanying text (describing the potential harms AZT and other MTCT treatment can cause a woman).

compelled medical treatment is likely to create more public health problems by damaging the doctor-patient relationship, placing doctors in the position of seeking court orders in more situations, compromising prenatal care, and driving women in need away from the health care system.¹⁹⁸

III. THE CASE AGAINST COMPELLING TREATMENT

A. Fetal Life Versus Fetal Health

There is an essential distinction to be made between the case law establishing state interests that can override a pregnant woman's right to refuse medical treatment and the scenario being addressed. The distinction is one of life versus health. *Cruzan* established that the state's interest in preserving life can limit a person's right to refuse medical treatment.¹⁹⁹ The abortion case law recognizes the state's authority to protect the fetus due to a compelling interest in the potentiality of life.²⁰⁰ Court-mandated forced blood transfusions and c-sections in the name of this compelling interest are troubling. Moreover, this interest is unpersuasive and not analogous to the case of a pregnant woman with HIV refusing MTCT treatment because there is no actual threat to the life of the fetus. The cases described do not establish or recognize a state interest in protecting the *health* of the fetus that would be strong enough to overcome such an important liberty interest.

In fact, in the cases mentioned, nearly every discussion about the fetus is in regard to life and the right to live. Meanwhile, any statements about health virtually always relate to the state's interest in the health of the pregnant woman. For example, in *Roe*, the Court finds that a woman's right of privacy can be weighed against "another interest, that of health of the mother or that of potential human life" at a certain point during pregnancy.²⁰¹ Any discussion of health in the opinion is only in reference to the "important and legitimate interest in the health of the mother."²⁰²

This interest is recognized again in *Casey*. The Court finds "the State has legitimate interests from the outset of the pregnancy in protecting the health of

198. Kaplan, *supra* note 107, at 203-06. *See infra* Part III.B (discussing additional public health consequences).

199. *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 271 (1990).

200. *See Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) ("[T]he government may use its voice and its regulatory authority to show its profound respect for the life within the woman."); *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 879 (1992) (reaffirming *Roe*'s holding that the state can regulate abortion after viability due to its interest in the potentiality of life); *Roe v. Wade*, 410 U.S. 113, 164-65 (1973) ("[T]he State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.").

201. *Roe*, 410 U.S. at 159.

202. *Id.* at 163.

the woman and the life of the fetus.”²⁰³ Most references to health in *Casey* are intended to make plain that state regulations on abortion must include exceptions for the woman’s health.²⁰⁴ This pattern follows in *Carhart* as well, given that the absence of an exception for the woman’s health was one of the primary issues that the Court needed to address.²⁰⁵

Even the *Jefferson* case, which found it justifiable to force a c-section on a woman for the benefit of the child, focused on the life of the child. The lower court held that it was “appropriate to infringe upon the wishes of the mother to the extent it is necessary to give the child an opportunity to live.”²⁰⁶ The court was concerned with giving the fetus the opportunity to live, not with the type of life it would have.²⁰⁷ This is most likely due to the fact that a pregnant woman is not obligated by law to ensure a certain level of mental or physical health of the child at birth.²⁰⁸

Cases that have dealt with the health of the fetus or newborn when the pregnant woman has ingested drugs or alcohol still have refrained from trampling on the constitutionally protected rights of the mother.²⁰⁹ In *Whitner v. State*,²¹⁰ the court found a compelling state interest in protecting the life and health of the fetus, which the court recognized as a person.²¹¹ Yet, the court here did not uphold any forced treatment or isolation of the mother to ensure she did not ingest drugs. Instead, it upheld a criminal prosecution of the mother after the birth of the child. Therefore, this case does not create precedent for forcing MTCT treatment on a pregnant woman. This is supported by the court’s own admission that they were not dealing with a mother simply exercising a fundamental right, because there is no constitutionally recognized right to privacy that encompasses cocaine use.²¹²

In *Ferguson v. City of Charleston*,²¹³ where the suspects were pregnant women believed to have ingested cocaine, the Court found an unreasonable invasion of bodily integrity when the hospital utilized warrantless and nonconsensual drug tests for criminal investigations and coerced the women

203. *Casey*, 505 U.S. at 846.

204. *Id.* at 872.

205. See *Carhart*, 550 U.S. at 161-68 (discussing whether an exception for the woman’s health was necessary in the Act in question).

206. *Jefferson v. Griffin Spalding Cnty. Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981).

207. See *id.* at 460 (discussing “the duty of the State to protect a living, unborn human being from meeting his or her death before being given the opportunity to live”).

208. *In re Baby Boy Doe*, 632 N.E.2d 326, 332 (Ill. App. Ct. 1994).

209. This discussion focuses on drug cases, but the alcohol cases hold true to the point that the state usually seeks punishment after the fact rather than forcing the woman to undergo substance abuse treatment or to take any particular medication.

210. 492 S.E.2d 777 (S.C. 1997).

211. *Id.* at 785.

212. *Id.* at 786.

213. 532 U.S. 67 (2001).

into substance abuse treatment under threat of criminal sanctions.²¹⁴ The Court held that it could not trample the women's constitutional rights despite finding a substantial threat to the fetus.²¹⁵ These drug ingestion cases provide a more analogous example of pregnant women making decisions that affect the health of the fetus that most, if not all, of society would find objectionable. Nevertheless, these morally questionable decisions and potential harm to the fetus that could cause lifelong effects have not caused courts to find forced treatment permissible.

By examining the establishment of state interests in the fetus, it is apparent that there has yet to be a detailed recognition of fetal health that should prevail over a woman's right to refuse medical treatment. Because the fetus maintains an opportunity to live, forcing on the mother a drug regimen that may require observed therapy or confinement²¹⁶ would shock the conscience, especially considering that courts have refused to force medical procedures on criminals even when they are purportedly in pursuit of justice and truth.

Although the following cases may not appear to parallel the issues surrounding a pregnant woman and her fetus, it is important to note where courts have drawn lines with regard to forced medical treatment. For example, in *Rochin v. California*,²¹⁷ the Supreme Court stated that forcing a suspect to submit to a stomach pump without consent was beyond civilized conduct despite police officers witnessing him swallowing morphine capsules to destroy evidence.²¹⁸ Similarly, in *Winston v. Lee*,²¹⁹ the Court refused to compel an alleged robber to undergo surgery in order to remove a bullet in his chest and to confirm his crime because to do so would be an invasion of bodily integrity too intrusive to permit.²²⁰

Given the hesitation that the Supreme Court has shown toward forcing medical treatment on criminals, it is disturbing to think that pregnant women "guilty" of nothing more than becoming HIV-positive at some point in their lives would be held in less regard. If the quest for truth and justice and the state's interest in protecting society from criminals are not compelling enough to force medical treatment, it seems illogical to hold that reducing the chance of a fetus acquiring a chronic disease should pass constitutional muster. These cases illustrate the importance of drawing a line where the state's interest cannot completely extinguish a person's right to be free from bodily invasion,

214. *Id.* at 78-80.

215. *See id.* at 86.

216. *See* Mutcherson, *supra* note 25, at 236-37 (discussing the difficulty that pregnant women who voluntarily undergo MTCT treatment have in complying with the lengthy and demanding treatment schedule).

217. 342 U.S. 165 (1952).

218. *Id.* at 173.

219. 470 U.S. 753 (1985).

220. *Id.* at 764-66.

even when the health of a fetus is involved. To find otherwise and to ignore the liberty and autonomy of a pregnant woman by forcing MTCT treatment by court order “would be to afford brutality the cloak of the law.”²²¹

B. Words of Warning from Public Health

In another case related to fetal health, *Johnson v. State*,²²² the Supreme Court of Florida invalidated an interpretation of a law that would have allowed criminal prosecution of women for transferring drugs to their baby after birth but before the umbilical cord was severed.²²³ One of the primary concerns of the court was that this policy, aimed at improving fetal health, would actually have the opposite effect.²²⁴ Fear of prosecution could cause a woman whose addiction was too overpowering to abort the fetus or avoid the health care system entirely, separating an unhealthy newborn from those who could best address the baby’s health needs.²²⁵ Looking at legislative history, the court recognized that the legislature specifically rejected criminalization for this reason, and the court felt that the most effective approach to the public health problem would be education and treatment programs.²²⁶

The decision over whether or not to compel MTCT treatment carries must be made in light of the same potential public health hazards. Forced medical treatment could drive HIV-positive women and newborns who may have HIV from the health care system, creating more of a public health problem. Most HIV-positive women are women of color and are poor,²²⁷ and many in these communities already distrust the medical profession and have doubts about turning to the health care industry for care.²²⁸ Forcing medication may exacerbate this tension and increase the trepidation that already exists between the medical profession and minority populations, causing people to forgo testing and refrain from involving hospitals in their pregnancies.

HIV-positive women are three times more likely to have children than HIV-positive men, and 28% of HIV-positive adults in the United States have at

221. *Rochin*, 342 U.S. at 173.

222. 602 So. 2d 1288 (Fla. 1992).

223. *Id.* at 1296.

224. *Id.* at 1294.

225. *Id.*

226. *Id.* at 1293.

227. Mutcherson, *supra* note 25, at 243.

228. See Aziz & Smith, *supra* note 21, at S234-35 (discussing the lack of trust that exists within the African-American community for health care providers and the medical community, and the need for culturally competent care to improve trust with HIV-infected women of color); Kaplan, *supra* note 107, at 205 (observing that “low-income women have more difficulty finding a physician, much less the flexibility to choose a physician that will respect their decisions”); Squires et al., *supra* note 20, at 283 (examining the effects of stigma and poverty on access to health care).

least one minor child.²²⁹ Any anxiety created from compelled medical treatment of pregnant women has the potential not only to deter them from relying on the health care system, it may create a swell of fear that prevents the HIV-positive community from seeking care for themselves or the children they have already had. Furthermore, this type of approach misconstrues what is perhaps the larger problem: combating the transmission of HIV in general, not simply between mother and child. Placing a larger emphasis on fighting HIV in general, whether through promotion of getting tested, condom usage, or some other public health intervention, is likely to reduce the amount of children born with HIV while reducing the number of adults carrying the disease as well.

An HIV-positive woman who rejects MTCT treatment is unlikely to make this decision based on her desire to harm the fetus.²³⁰ With this in mind, there are more appropriate means of reducing HIV transmission rates. If a woman rejects a doctor's recommendations, other options are available. Continuous education, counseling, and encouragement to speak to others are much more appropriate responses that are more likely to have the desired impact.²³¹ These methods have the added benefit of respecting a pregnant woman's autonomy by providing information for informed consent, rather than disregarding ethical principles of medical care and eroding the constitutional rights of pregnant women.²³² While HIV is a legitimate health concern, state intervention in this case would push society farther down a slippery slope with potentially no end to the interest in fetal health, rather than fetal life.²³³

C. Relegating Pregnant Women to Second-Class Status

Given the fact that autonomy and liberty interests are accepted as essential and constitutionally protected, the potential authority to compel treatment for pregnant women raises the question of whether this treats them as distinctly

229. *Id.*

230. See generally McDonald & Kirkman, *supra* note 26, at 580-81 (describing the survey responses of women who refused MTCT treatment, which included a lack of faith in the treatments recommended, knowing their viral load was low, risk of toxicity, and distrust in medical personnel who were perceived to be uninterested in listening to the thoughts and concerns of the patient).

231. See *In re Baby Boy Doe*, 632 N.E.2d 326, 335 (Ill. App. Ct. 1994) (finding that urging a woman to seek consultation and counseling is a more suitable option than forcing procedures).

232. See Kaplan, *supra* note 107, at 156 (stating that if informed consent is a concern, providing sufficient information regarding the risks and benefits is a necessary step to avoid depriving a woman of her autonomy).

233. For example, one can envision a scenario in which a woman is subjected to a court order due to unhealthy eating or failing to live a healthy lifestyle in general. See *Johnson v. State*, 602 So. 2d 1288, 1294 (Fla. 1992) (arguing against the criminalization of mothers for transmission of harmful substances through the umbilical cord after birth, given that every pregnant woman who ingests a potentially harmful substance could be criminally liable).

different from the rest of society.²³⁴ Allowing state interests to override a pregnant woman's right to refuse medical treatment and essentially forcing her to submit to what society deems to be appropriate care leaves her with less autonomy in a manner that a man or nonpregnant woman would not have to suffer.²³⁵ If a man or nonpregnant woman has his or her right to refuse treatment superseded, his or her status as male or nonpregnant is merely incidental, if not irrelevant, to this decision. This clearly distinguishes pregnant women from the rest of society as a unique class whose liberty may be limited if their medical decisions do not comply with what is seen by society as proper.²³⁶ The ability to limit a pregnant woman's autonomy largely stems from the simple fact that she became pregnant, a characteristic that is unique to this class of individuals.

Indeed, the *Casey* court emphasizes that while the woman is to make the ultimate decision, she does not have the right to do so in isolation from other parties.²³⁷ Despite the fact that *Casey* focuses on abortion rather than the health of the fetus, this type of reasoning could be extended to justify a claim that pregnant women do not have the right to place their own health ahead of the health of the fetus.²³⁸ Implications that women are less autonomous simply because they became pregnant lack clear reasoning, especially when they lend support to the notion that the state can "commandeer their bodies because of their reproductive capabilities."²³⁹ The notion that any woman who chooses to continue her pregnancy to the point of viability is consenting to the presumption that her fetus's health interests substantially or completely outweigh her own constitutes a legal fiction that justifies ignoring a woman's wishes and divorcing her constitutional rights from a continued interest in self-autonomy.²⁴⁰

A perhaps more frightful reasoning behind state intervention, which appears to drastically reduce the respect for a pregnant woman's ability to make an informed decision, is the *Carhart* Court's use of emotion and potential

234. See Kaplan, *supra* note 107, at 186-89 (finding that compelling medical treatment designates pregnant women as a special class of citizens with limited autonomy undeserving of equal constitutional protection).

235. See *id.* at 189 (finding that a state determination of what risks a woman is to assume for the benefit of the fetus is a physical appropriation of the pregnant woman's body).

236. *Id.* at 191.

237. *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 852 (1992). The Court came to this conclusion because a pregnant woman's decisions have implications not only for the woman, but also for those physicians caring for her, her spouse, her family, and society. *Id.* at 852.

238. *Contra Cherry*, *supra* note 158, at 595 (stating that the court has indicated that a woman has the constitutional right to place her health first, and the state must respect this right even after viability).

239. Kaplan, *supra* note 107, at 149.

240. See *Casey*, 505 U.S. at 870 (reasoning that "it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child"). This reasoning ignores the variety of factors that may have played into this decision, or lack thereof, such as the inability to access abortion services or incapacity to afford the procedure.

for regret.²⁴¹ This newly created state interest presumes that pregnant women do not have the same capacity to make informed medical choices or understand their own emotional state as other classes of citizens. This dangerous precedent, which essentially creates a new state interest in protecting a pregnant woman from herself, can have larger implications outside of abortion jurisprudence by justifying the state's insistence on what it regards as the reasonable medical decision.²⁴² This paternalistic view places constitutionally recognized rights at risk simply based on pregnancy, while subverting a woman's right to make choices regarding her own safety.²⁴³

Treating pregnant women differently in terms of their autonomy and capacity to make informed decisions about their medical treatment has substantial implications for equal protection. The ability of an HIV-positive pregnant woman to refuse MTCT treatment is a matter of personal dignity and autonomy, and lies at the heart of the liberty interest to define one's own existence.²⁴⁴ Certainly, "beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State."²⁴⁵ Yet notions of a woman's role in society and her capacity to make her own decisions while she is pregnant are reminiscent of a time when the constitutional protections of women were not seen as equal to those of men.²⁴⁶ This reliance on and reinforcement of normative gender roles has dangerous consequences, not only for state authority to compel pregnant women to undergo unwanted medical treatment, but for the constitutional protections of pregnant women.²⁴⁷ With such serious implications, it is vital that women retain the right to control their medical decision-making, including the right to refuse medical treatment that could benefit the health of the fetus.²⁴⁸

This danger of relegating pregnant women to second-class citizenship is more pronounced for those who are HIV-positive. Despite decades of attempts to educate and inform the public, there is still a stigma attached to the disease, which often creates social hardships for those who are HIV-positive. To be sure, HIV-positive persons, whether they are pregnant women or not, are frequently treated as second-class citizens. They are ostracized and even criminalized in certain circumstances.

241. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007).

242. Kaplan, *supra* note 107, at 160.

243. *Carhart*, 550 U.S. at 184 (Ginsburg, J., dissenting).

244. See *Casey*, 505 U.S. at 851 (finding that choices central to personal dignity and autonomy, such as refusal of medical treatment, are protected liberty interests).

245. *Id.*

246. *Carhart*, 550 U.S. at 185 (Ginsburg, J., dissenting).

247. See Kaplan, *supra* note 107, at 193, 199 (discussing earlier cases that permitted regulation of women's roles due to their ability to have children, and how this reasoning reverts back to burdening women in ways that do not apply to men).

248. Cherry, *supra* note 158, at 607-08.

For example, until 2011, the Mississippi State Health Department required HIV-positive people to sign a legal document stating that they would undertake measures to ensure they did not become or cause someone to become pregnant.²⁴⁹ This document could be used later as evidence for prosecutions of HIV-positive pregnant women under Mississippi's felony HIV exposure and transmission law.²⁵⁰ Despite a formal end to this practice, effects of the policy remain and it provides an illustration of the type of legal discrimination that persists in spite of advanced information on the disease.²⁵¹ For a court to abrogate an HIV-positive pregnant woman's right to refuse medical treatment would damage the advances made not only by women and pregnant women, but also by those living with HIV. Such an abrogation would enlarge the foundation on which negative assumptions are already based, while potentially driving these women farther from accessing the health benefits they need.

These troubling prospects become more ominous when considering that most HIV-positive women are minority women of low socioeconomic status.²⁵² As such, these women largely belong to groups of citizens and persons that have been historically marginalized. To override the rights of these women as HIV-positive pregnant women would compound the subjugation of these groups. Courts have an important role to play in protecting the autonomy and rights of everyone. When examining what the characteristics of many HIV-positive pregnant women might be, it becomes imperative that the courts use caution in subverting rights that are supposed to be constitutionally protected. To create precedent that conditions people's rights on these types of characteristics would be to head down a perilous road.

CONCLUSION

While a case has yet to arise where the constitutional rights of an HIV-positive pregnant woman who refuses MTCT treatment are squarely in question, it seems inevitable that one will, especially given that women of childbearing age are the most vulnerable population for HIV transmission.²⁵³

249. Susana T. Fried & Brook Kelly, *Gender, Race + Geography = Jeopardy: Marginalized Women, Human Rights and HIV in the United States*, 21 WOMEN'S HEALTH ISSUES S243, S244 (2011).

250. *Id.*

251. *See id.* (stating that health care professionals were not retrained, which may preserve some of the previous negative consequences such as stigma and the fostering of misinformation).

252. *See Aziz & Smith, supra* note 25, at S231.

253. Despite the possibility of an HIV-positive teen becoming pregnant, this Article does not address issues surrounding adolescent decision-making and a minor's right to refuse medical treatment. Legal and ethical debates surrounding adolescent decision-making can incorporate many issues, including the scope of a minor's right to refuse treatment, including life-saving treatment, over the objections of his or her parents. *See Amanda C. Pustilnik & Leslie Metzger Henry, Introduction: Adolescent Medical Decision Making and the Law of the Horse*, 15 J. HEALTH CARE L. & POL'Y 1, 1 (2012).

The recent justifications utilized in *Carhart* raise serious concerns about the status of pregnant women's rights and liberties when combined with past cases of compelled medical treatment of pregnant women. If state interests in fetal life develop into a compelling interest in fetal health, there could be wide implications beyond HIV-positive pregnant women. There is a need for the judiciary to recognize the rights of pregnant women to control their lives and their bodies, rather than treating them as a distinct class of citizens whose interests do not deserve the same protection as others. With a proper reading of the interests and authority of the state weighed against the constitutionally protected rights of the pregnant woman, it becomes clear that the woman's liberty interests in refusing MTCT treatment should carry the day.